Managing Death Issues in the School

Monograph Series No. 1

Guidelines for Managing Death Issues in the School

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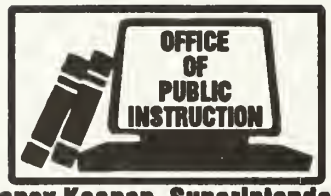

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Dear Educators, Administrators, Parents and Community Friends of Education,

This monograph is one in a series of papers that focus on contemporary issues in Montana schools. It is our hope that the research and resources contained here will build awareness and identify skills that will be helpful to you in addressing some of the most pressing and relevant topics confronting our students and staff today.

The information is designed to clarify key problems, identify strategies to affirm students, and provide school personnel with knowledge and information to make good decisions. Many of these contemporary issues involve difficult barriers (both subtle and overt) to educational equity guaranteed by the Montana Constitution.

This series is designed to present in a brief and concise format the newest research, ideas, and successful practices of educators across the nation. We are sensitive to your need for current information as you are faced with critical decisions involving curriculum, educational equity, and the demands and concerns of your community members. Resources, research and technical assistance on successful practices will be included in each monograph.

One of my priorities is to assist educators, administrators and community members in solving contemporary problems in education so that our students receive the best preparation we can give them for full and productive lives. I sincerely hope these monograph issues will be a strong contribution to our joint efforts to put Montana's children and youth first. Your reactions and responses to this monograph series are welcomed.

Sincerely,

Nancy Keenan

Acknowledgements

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The University of Montana Department of Social Work and the Fourth District Youth Court have provided the services of Bob Deaton and Dan Morgan to organize and write the *Guidelines.*

Preface

Many schools have been dealing in various ways with youth suicide and other death-related issues. From the experiences of the schools and other community organizations over the past few years have emerged workable practices and procedures which can be implemented for general use.

Schools can now develop and implement comprehensive plans to deal with death issues using a variey of available resources. Experience indicates that the school's plan must incorporate policies and procedures dealing with the three components of prevention, intervention, and postvention activities.

The **Guidelines** has been developed to assist schools in creating their plans. It contains information on the causes of youth suicide and sucide's connection with high-risk, self-destructive behaviors. Information is presented to assist schools in developing the three program components. At the end of this document is a list of practical and readily available resources.

Table of Contents

Introduction

Statistics and Incidence of Major Causes of Death in Youth

Both nationally and in Montana, accidents are by far the major cause of death among young people. However, homicide is the second and suicide is the third leading cause of death across the United States. In Montana, accidents were first and suicide was the second leading cause of death among youth ages 5-14 and 15-24 in the years 1985-1988 (Montana Vital Statistics, Montana Health and Environmental Sciences, May 1991). Over the past few years, suicides in Montana have averaged two per year in the 5-14 age group and 25-30 among those ages 15-24 (Montana Vital Statistics, various years).

Cause of Death
Montana Youth - 1990
(Montana Vital Statistics, 1992)

	Age 5-14	Age 15-24
Accidents:	18	81
Cancer:	5	8
Suicide:*	2	31
Homicide:	0	7
Heart Disease:	3	13
Totals:	28	148

*Suicide is #3 for 5-14 and #2 for 15-24 year olds in 1990

Additional information from a 1991 statewide survey of Montana adolescents reported that 9 percent of male and 18 percent of female youth said they had attempted suicide (Montana Adolescent Health Status, 1990, p.12).

While the numbers seem small for the state, the rate of suicide per 100,000 population for all ages and for youth, in particular, is much higher in Montana than the national average (Hodgkinson, Harold, National Conference on School Health Leadership in State Departments of Education, 1992 and U.S. Bureau of the Census, Statistical Abstracts of the United States: 1991, 111th Edition, Washington, DC).

The Montana figures for 1990 deviated from the usual pattern of recent years due to the number of cancer incidents in younger children (5-14) and heart fatalities in the older group (15-24). However, in virtually every other year, suicide is the second leading cause of mortality among younger people in the state.

The statistics show that the three major causes of death and permanent injury in younger people are accidents, homicides, and suicides. While some are unavoidable, a great proportion of deaths and injuries derive from some combination of destructive behavior or thought, high-risk activities, low self-esteem and poor problem-solving ability.

During the past ten years, schools across the nation and in Montana have begun to develop comprehensive plans for dealing with death, especially suicide, as it affects the school setting. Schools have offered individual and group counseling and have provided opportunities for discussion for those affected by the death of a classmate (These are termed "postvention" activities). Attention has also been directed to preventing and intervening in the suicide attempts of children and youth. Prevention activities have taken the form of curriculum materials aimed at prevention that can be infused in the core curriculum and through elective courses in psychology and sociology. Schools have developed intervention procedures for assisting youth who are suicide prone.

More recently, current research on children, families, and community schools indicates that students can become resourceful, self-directing individuals who not only resist at-risk behavior but become successful, resilient adults. A variety of school programs, teacher initiatives, and student peer activities are being developed which help students bond with the school and meet high levels of social and academic achievement. Fostering Resiliency in Kids, written by Bonnie Benard at the Western Center for Drug-Free Schools and Communities, contains detailed information on ways schools can develop such programs (it is referenced in Resources).

Part I

UNDERSTANDING CAUSES OF YOUTH SUICIDE AND SELF-DESTRUCTIVE BEHAVIOR

It is popularly believed that depression or drugs and alcohol cause suicide. However, neither by themselves can be considered a single cause. Self-destructive behavior and suicide are derived from a complex set of components including adolescent development plus psychological, behavioral, and situational factors. Repeated disappointments or a history of suicide in the family may also contribute to self-destructive behaviors.

Adolescent Development

Developing a fully-integrated personal identity is the major task of adolescence (Erikson, 1968). Suicide attempts and hopelessness are often related to thoughts and feelings of youth who feel they have no identity or worth as individuals.

Lacking this feeling of self-approval, adolescents find the need for outside approval to be critical to their sense of well-being, and they keenly feel that others are constantly watching them, even if they are not (Elkind, 1975). Therefore, suicidal teens can develop the paradoxical idea that they will be missed as important, unique people if they die.

Adolescents' concept of time is that of the here and now. They have little appreciation or realization that important developments take time; therefore, they become frustrated and develop a sense of futility and impatience when things do not "happen" instantly. Modern culture encourages this sense of time distortion with its emphasis on fast-changing events and immediate gratification. Therefore, the need of youth for quick resolution and satisfaction makes them vulnerable to impulsive acts such as suicide.

Cognitive ability and brain function in youth are marked by an ability to think quickly and to memorize information better than adults. They are concerned philosophically and morally with important life issues. Unfortunately, they lack life's experiences to help them evaluate everyday occurrences, thus leading them to make hasty decisions filled with deep disappointments.

Psychological Causes

It is often assumed that self-destructive behavior is connected to short-lived depression or mental illness. Yet, many depressed and seriously mentally ill people do not commit suicide.

Hopelessness (anhedonia) has been identified by psychologist Aaron Beck (1985) as the most

important psychological factor leading people to commit suicide. Troubled individuals, unhappy with their lives, determine the chances for improvement to be nonexistent. Hopelessness, in turn, leads people to consider a potential plan for ending their lives.

Related psychological symptoms that heighten anhedonia include severe depression, conduct disorders, and the use of certain drugs, particularly alcohol.

Situational

Situational factors that could precipitate suicide attempts include such events as serious health problems, financial loss or failure at attempted goals. The approach of youth to these and other disappointments differs from older attempters in two ways which relate to developmental issues.

Adolescents expect resolution and gratification to occur instantly and may be unable to endure disappointment. Their reactions to such frustration explains the reason adults cannot understand why small incidents are so upsetting to young people.

There may be a personal list of disappointments which differ from those who are older or younger than adolescents. These factors include"breaking up" from the first important love relationship, getting a low grade or not making a varsity sports team.

Situational disappointments with youth are often related to peer approval, although family conflict or lack of parental support can also be important factors.

Developmental issues of youth, psychological causes, and situational components must be considered when planning and implementing the suggestions described in the Guidelines.

Part II

CONSIDERATIONS FOR PLANNING SCHOOL GUIDELINES

Any plan dealing with youth suicide must consider the needs of school and community, the responsibilities of the school, and the services the school and community can offer.

Major Components of the School Plan

The three components of a school plan deal with prevention, intervention, and postvention.

Prevention is any planned effort to prevent death or other self-destructive behaviors. Activities include implementing a prevention curriculum, training school personnel and parents to recognize early symptoms, and organizing social skills development groups for students.

Intervention consists of activities which are designed to stop suicide attempts. These include immediate response counseling, therapy, referral, hospitalization and other medical services.

Postvention is comprised of all planned responses to a death of a school member such as counseling sessions for students and debriefings for school staff.

Administrative planning must include decisions about the range of services and activities the school or district will undertake in the three component areas and the legal liabilities involved.

Considerations for Developing Policy Guidelines

A committee, appointed by the school administrator, is assigned the task of developing a tentative plan and set of guidelines that address the components of prevention, intervention, and postvention. To accomplish this task the committee must answer several questions. Have steps been taken to prevent suicide, self-destructive behavior, and low self-esteem in students? Are there procedures and adequate staff in place to deal with suicide and other destructive behaviors? Does the school have a comprehensive plan in place to deal with the death of a student?

The guidelines need to clearly describe the required procedures and the personnel responsible for implementing these actions. Information and training must be given to those responsible for executing the various activities.

The tentative plan must be reviewed and approved by top administrators and school trustees. Legal issues and risks must be evaluated by the administration, board members, and legal counsel for the district. Usually, the best way to reduce professional liability for the district, its board, and its personnel is to establish a clear and comprehensive plan and then train staff to implement the plan.

All school personnel must be given training on the guidelines. More specialized training should be given to teachers, counselors, and others who will provide counseling, make referrals, and implement curricular changes.

MOST IMPORTANT

Schools must:

1. provide training and information on how to recognize suicidal symptoms in students,
2. provide some form of immediate intervention,
3. notify parents, and
4. know about referral services.

Part III

IMPLEMENTATION FOR PREVENTION, INTERVENTION, AND POSTVENTION

The programs conducted in the schools and those provided in concert with community groups constitute prevention, intervention, and postvention activities.

Prevention Guidelines

Initiating a comprehensive program can have a strong preventative effect on students by communicating to them that the school is concerned about preventing or mitigating undue personal pain and self-destructive behaviors. Prevention efforts should include examining all school activities for their potential in promoting positive feelings and behaviors in students.

Disciplinary actions need to be evaluated for their effect on the student as well as their effectiveness in controlling behavior. Punishment must never by intent belittle or attack the personality of the individual in such a way as to implant such labels as "jerk," "dunce," or "total failure."

The core curriculum at grade levels can be infused with suicide prevention information. Health, social studies, and literature components should receive particular attention. (For details see Appendix B: A Guide to Curriculum Planning in Suicide Prevention.)

The health curriculum typically deals with self-esteem and personal problem-solving skills. Managing personal issues concerning death, dying, grieving and loss can be introduced in existing units.

Literature units often focus on material about young people coping with death issues in their personal lives. Bibliotherapy, the reading of books dealing with issues that are troubling the individual, is a useful prevention and intervention activity for younger and older students. (For an excellent discussion and list of books, refer to Bernstein, Joanne, Books to Help Children Cope With Separation and Loss, in the Resources List.)

Using curriculum materials to teach children and older students about death and how to cope with it will assist students in perceiving death as being a normal event. It will also provide them with the needed information to have a healthy perspective on death, dying, and grieving. Thus, they are not unduly preoccupied with such thoughts, nor do they underestimate the effect of death and the grieving process.

At the Elementary level, self-esteem is introduced as a cognitive skill in the early grades along with understanding feelings and thoughts about self and others. Developing positive actions and personal problem-solving is introduced as a coping skill. Managing one's own grief and loss can be an additional component. While the subject of death can be presented briefly and factually with young children,

students at sixth grade are at a developmental stage where they may fully understand the reality and finality of death.

Secondary schools can continue to enhance the self-esteem of older students and help them develop internal resources to counter threats to the ego. During their time in high school, students can be instructed in developing stress management skills and creating a personal self-help plan that can help them deal with disappointment and pressure.

Also, understanding suicidal thoughts and feelings and their causes are concepts that should be introduced to high school students. The warning signs and getting help for self and others who are thinking about or attempting to take their own lives can be explained through group discussions or peer counseling activities.

Intervention Guidelines

All efforts designed to stop suicidal behavior are considered intervention. More specifically, there is a need to develop an intervention plan, establish procedures for recognizing the signs and symptoms of suicide and to offer treatment or other services.

Ogden and Germanario (1988, pp.111-118) suggest the following general school policies and set of procedures for handling suicide attempts:

1. Establish procedural guidelines for handling situations which may result in self-inflicted harm.
2. Report all potential suicide situations to the principal and school counselor.
3. Staff will be "held harmless" for reporting information on potential suicide.
4. Staff cannot be required to guarantee confidentiality, and even if it <u>were</u> promised, the responsibility clearly is to share needed information with appropriate others, including administrative staff, parents, and anyone providing treatment for the suicide attempt.
5. The school has the responsibility to gather information from the student and others concerning a possible suicide.
6. If the student is at extreme or high risk, a staff member must remain with the student.
7. A suicidal student should not be allowed to leave school until a safety plan is assured.
8. Parents have the right to know when their child is at risk, and they have the primary responsibility to provide treatment.
9. The school has the responsibility for ongoing support of a student at risk within the limits of its resources.
10. Parents and treatment agencies can count on the cooperation of the school in assisting the child at risk.

Recognition and Intervention Measures

In addition to these ten general guidelines, there are specific steps for assessment and intervention in suicide attempts which identify three different kinds of suicidal behavior: moderate-risk, high-risk, and extreme-risk individuals. Those at **Moderate risk** could definitely engage in suicide attempts but have some internal controls and are willing to talk with others about their alternatives. **High-risk** attempters have likely made tangible plans and would carry out a suicide attempt without some kind of intervention. **Extreme-risk** individuals, who include those who have made previous attempts, will immediately act if there is no monitoring and control of their actions.

Steps to be taken with those at each level are listed separately:

Moderate-risk suicide attempter

- Express concern and explore the thoughts and feelings of the student. Explain the limits of confidentiality if a suicide attempt appears likely.
- Determine how much the parents know about the student's feelings about suicide. Notify parents if apparent need indicates.
- Refer the student to a school counselor or psychologist, if indicated.
- Provide the student with a list of mental health professionals in the community.
- Provide weekly contact and support.
- Inform school staff who are in daily contact with the student about the risk and request that they provide regular monitoring and support.
- Consider the use of short-term counseling or peer-group support at the school.

High-risk suicide attempter

- Refer the student to a school counselor and notify the principal.
- A counselor must meet with the student and assess the seriousness of the attempt.
- The means and plan for the suicide attempt should be evaluated.
- If present, such items as pills, poison, or fire arms are to be removed. (However, the safety of the intervener must be considered when making decisons on removing the means from a suicidal person.)
- Contact the parent or guardian and inform them of the school's efforts. Determine whether the student is receiving counseling and if the therapist is aware of and treating the suicide issues. If not, suggest appropriate treatment resources.
- Monitor the behavior and mood of the student throughout the day.

Extreme-risk suicide attempter

- The student must not be left alone.
- Parents or guardian must be notified immediately and be requested to come to school.
- The staff member involved with the student and the principal will meet with the parent to discuss the situation and develop a plan of action.
- The student can only leave the school with a parent or mental health professional.
- A staff member will follow up the next day with the student.
- Teachers and other staff members regularly involved with the student will be informed of the outcome.
- The school will collaborate with the primary treatment agency or therapist of the suicidal youth.

(Deaton and Morgan, Intervention Hand-out Packet on Teen Suicide, contains details for strategies and techniques and is contained in Appendix C.)

Postvention Guidelines

The major purposes of postvention include assisting students and school staff with their feelings and thoughts and helping them to bring some closure to the event. It is also a way to show respect for the deceased and provides humane support for grieving school members.

Postvention activities are conducted at the school for students and for staff usually the day after a death. Postvention response is not to be limited to student suicide but is considered regardless of the circumstance of the death of the school member.

The following components for an intervention plan are adapted from Ogden and Germanario's book (1988, p. 122):

- Gather factual information about the circumstances of the death from family, law enforcement, or other direct sources.
- Initiate the response plan of the school.
- Communicate factually and quickly with all staff and students about the death.
- Maintain the usual, daily schedule as far as possible.
- Provide individual and group support for students:

    1. Provide a group session for close friends of the person.
    2. Have a drop-in counseling room throughout the day for students and school staff, with a designated counselor present.

3. A staff member can follow the regular schedule of the student, i.e."empty desk" procedure, the day after the death to answer any questions from other students. Do not remove the desk or locker assignment for two days.

- Designate two staff members to have all contacts with the news media and the public about the death.
- Do not let students or staff who are very upset go home without someone to accompany and stay with them.
- A memorial service should not be conducted by the school, but schools should support services arranged by family or friends.

Developing a response plan

- Select at least two staff members who can deal with the media and the public.
- Select a counseling team to provide grief assistance in group sessions and individual meetings with students and school staff.
- Conduct a planning meeting with all team members and administrators to discuss the plan and likely situations that may occur.
- Arrange training for counseling staff team members.

Response to faculty and staff needs

- An administrator or counseling team member is designated to personally contact any staff member who was very close to the deceased.
- A member of administration and the counseling team meet and discuss the need for a critical incident debriefing.

  (See Appendix D: "Taking Care" for an explanation of debriefing.)

- If a formal debriefing is indicated, it needs to be conducted within three days following the death utilizing an outside debriefing team. (See **Appendix D**: "Taking care of those who take care: A debriefing guide for school members.")

Part IV

TRAINING PLAN

The training of building staff is needed to familiarize them with the signs and symptoms related to suicide, to understand the intervention and referral components, and to familiarize them with the immediate grief processes and postvention procedures.

More specialized training is provided to staff members who will be conducting intervention services and to those who will be on the postvention response team.

Training for all Building Staff

General training topics need to include the scope of the problem, youth suicide statistics, and the school's role in youth suicide prevention, intervention, and postvention. Personnel need basic information on causation including adolescent development, anhedonia, the roles of depression and drugs, and situational causes.

In the area of intervention, staff need to be able to recognize the signs of suicidal behavior and thought, to know how to provide immediate intervention, and to make referrals.

Understanding the postvention process, recognizing the need for it in self and others, and being a good participant are training needs.

Specialized Training for Designated Staff

Counselors, administrators, and other specialists require training in understanding the dynamics of self-destructive behavior in young people, how to diagnose it, and how to provide intervention.

The different applications of assessment, referral, and treatment as applied to moderate, high, and extreme-risk students are essential topics.

Postvention training begins with how to develop guidelines for a postvention plan. Then techniques for assisting individuals and groups with grief and loss must be implemented. The final component is to learn how to determine the need for formal critical incident debriefings and how to conduct them.

Part V

COLLABORATION BETWEEN THE SCHOOL AND OTHER GROUPS

Schools frequently join with other community groups to develop projects of mutual interest to assist local youth. These typically include suicide prevention efforts, coordination of services, development of new programs, and community education. Small rural areas with few resources may want to collaborate with other communities for training or sharing services (see Appendix B: A Guide to Curriculum Planning in Suicide Prevention).

Suggested steps and projects include beginning with a public meeting where interests and priorities can be gauged and then a steering committee can be formed composed of committed individuals. (It is important to include youth from the community on any planning committee.)

Next, it must be determined how local programs and agencies can work together on projects of mutual interest in youth suicide prevention. It is important that the school involve other child, youth, and family services of the community in order to coordinate existing resources with the school.

Part VI

CONTENT SUMMARY

Prevention

All efforts designed to prevent self-destructive thought and activity, promote positive self-esteem, and teach skills in personal problem-solving constitute prevention.

A planned set of activities enables students to increase their understanding and ability to deal with the concept and reality of death, to cope with ideas about suicide, and to successfully manage life stresses.

A comprehensive plan includes reviewing school activities such as sports, music, science fairs and student government for their balance between competition and participation. Competitive activities help students sharpen abilities, develop self-discipline, and savor the fruits of excellence. However, all students need the experience of enjoying the act of being a participant.

Student discipline policies in the school must be evaluated for their effect on self-esteem and self-worth. Measures that are harsh or arbitrary may reinforce feelings of worthlessness or hostility.

The prevention curriculum begins with self-esteem building and personal coping strategies at the K-6 level. Also included are selected topics about death, dying and the grief process. Concepts and techniques for dealing with suicide should not be presented before the sixth grade (see the Wisconsin Department of Public Instruction's A Guide to Curriculum Planning in Suicide Prevention chart in Appendix B for a topical content listing by grade level).

In selecting materials for the prevention curriculum, it is important to normalize the concept of death with students by utilizing historical, biographical, or fictional literature that deals with death themes. *Hamlet*, *Romeo and Juliet*, and *The Bell Jar* are examples which enable students to see that suicide is a problem with which people have always had to cope.

Intervention

All efforts to assess, stop, deter, and treat self-destructive behavior which is imminent or in process comprise intervention.

Teen suicide intervention differs from other personal and family counseling because of the need for immediate and continuous response to prevent the lethal, irreversible actions of suicidal behavior. Suicide is characterized as the "preventable death." It is true that very often youth will choose to live if they can be helped through a suicidal episode.

Training in recognizing signs and symptoms, initial assessment, and referral of suicidal youth must be provided to all school staff who are in contact with students. School counselors, social workers, psychologists and other staff specialists must have specific training in such areas as crisis intervention, ongoing counseling, group facilitation and referral.

Initial contact with the suicidal person must be characterized by showing concern for the person and attempting to understand the thoughts and feelings behind the suicidal gesture. It is inappropriate and dangerous to dispute or trivialize the reasons young people give for attempting suicide. Suicidal attempts must always be taken seriously, even if it appears that the person does not intend to carry them out. It is always significant that the person has selected a self-destructive behavior rather than acting out against the environment or other people.

The actively suicidal student must be monitored by someone at the school and at home. The counselor not only must express concern for the student, but must strongly assert a request that the individual not attempt suicide, even if only a brief time-limited commitment is secured. If a referral is made for treatment to an outside agency, the student should be accompanied to the appointment.

Available peer and support group services for students, which do not specifically focus on suicide issues, should be considered for inclusion in the intervention guides. (Self-esteem building and drug and alcohol-focused groups are often helpful as part of the treatment process with suicidal teens.)

Treatment and counseling offered after the assessment phase should be active and direct and offer support to the student. Rational-emotive therapy (RET) is often used because it focuses on challenging unrealistic, self-defeating thoughts, and uses interpretation and teaching methods to help the person plan and manage troublesome issues (see Rational-Emotive Therapy With Children and Adolescents, by Bernard and Joyce in the Resources list). The counselor can use RET to engage the young person in exploring ideas and feelings which lead to self-destructive actions. Then, problem-solving approaches can be employed to help the person explore alternatives to suicide and try positive solutions. Continual, expressive support is necessary to motivate the individual to attempt other avenues and to overcome unconfirmed feelings that no one cares.

Because intervention requires considerable counselor time and specialized knowledge, the school may choose to refer a student to other agencies and private therapists. Case coordination and management are often required when the student or her/his family is involved in related counseling outside the school. The counseling efforts of all professionals involved with the student and family must be in harmony. The school can provide information to outside treatment specialists about the progress and behavior of the student. School counselors and teachers need to receive suggestions from therapists on how to work with the person in the school setting. Procedures for case coordination and management are appropriate for inclusion in the Guidelines.

Postvention

Responses immediately following the death of a school member comprise the postvention plan. Decisions about the circumstances, conditions, and responses which the school will employ constitute the postvention activities. It is essential to provide a respectful, healing response to the death of a close staff associate or a student. Administratively, postvention is a way to have some control of the situation and to provide needed services that are difficult to mobilize when people are upset or grieving.

Questions to be considered in determining the response of the school are: What is the meaning of the particular occurrence to school members? Was it caused by accident, suicide, or illness? Was it expected or unexpected? Was it a single or multiple casualty? Did it occur at the school, out in the community, or further away? Did it occur during the school term or during vacation? What are the wishes of the family and intimate associates? Finally, does the school need the assistance of outside resources in the situation?

The crisis counseling team described in the school plan is selected in advance and usually consists of counselors, psychologists, or school social workers. In small districts, a team from several surrounding schools can be assembled. A general rule is to select twice as many members as are usually needed. Prospective team members may need special training and they should be allowed to turn down the assignment if they are not comfortable or professionally qualified to deal with issues of death and grieving.

Some crisis team members can be assigned to counseling rooms or to meet with a small group of close friends of the deceased the day after the death. Others can be assigned to the "empty chair" activity of following the student's schedule for the day.

Some districts have clinical psychologists or counselors in private practice whom they call upon to assist as crisis counselors. If clergy are involved, it is important to know the religious wishes of the deceased, family, and close associates.

Critical incident debriefing should be considered for teachers and staff. The debriefing is usually conducted one to three days following the death, and is conducted in an uninterrupted, private group setting. The focus is to help individuals express grief, air their thoughts about the incident, and gain a sense of closure (see Appendix D for details). Debriefings will need to be conducted by an outside team of trained people. In many communities, county teams can be contacted through Public Emergency Services telephone numbers or Employee Assistance Programs.

Part VII

RESOURCES

DEVELOPING SCHOOL GUIDELINES:

Browning School District, Suicide Intervention Policy: District 9, Browning, MT.

Galusha, Richard. Omaha Student Suicide Prevention and Intervention Programs, Psychological Services, Omaha Public Schools, 3819 Jones St., Omaha, NE 68105.

Great Falls Public Schools. Policy and Procedures: Suicide Issues and High-Risk Youth, Great Falls, MT.

Konet, Richard. "Developing A Suicide Intervention Program In Your School," NASSP Bulletin, February 1986.

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PREVENTION:

Benard, Bonnie. Fostering Resiliency In Schools, Western Regional Center for Drug-Free Schools and Communities, Portland, OR.

Great Falls Public Schools. Teens In Crisis (Pamphlet Series), How Students Can Help, How Parents Can Help, Staff Handbook, Great Falls, MT.

Polly, Joan. Preventing Teenage Suicide, Human Sciences Press, 1986.

Smith, Judie. Suicide Prevention: A Crisis Intervention Curriculum for Teenagers and Young Adults, Learning Publications, Holmes Beach, FL, 1989.

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INTERVENTION:

Bernard, Michael and Joyce, Marie. Rational-Emotive Therapy With Children and Adolescents, Wiley and Sons, NY, 1984.

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Human Relations Media. Suicide Prevention: A Teacher Training Program, (available in filmstrip or VHS videotape), 175 Tompkins Ave., Pleasantville, NY 10570-9973

Montana Office of Public Instruction, Counselor's Resource Guide, Helena, MT, 1986.

Patros, Philip and Shamoo, Tonia. Depression and Suicide in Children and Adolescents, Allyn and Bacon, 1989.

Pfeffer, Cynthia. The Suicidal Child, Guilford Press, 1986.

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Community Intervention, Inc. Adolescent Suicide: Identification and Intervention, Western Center for Drug-Free Schools, 101 SW Main St., Suite 500, Portland, OR 97204.

Cunningham, Bruce and Hare, Jan. "Essential Elements of a Teacher Inservice Program on Child Bereavement," Elementary School Guidance & Counseling, February 1989.

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Appendix A

LEGAL AND

ADMINISTRATIVE ISSUES

Sample Emergency Procedures
School Response for Dealing with Tragic Death or Attempted Suicide

The death, suicide, or attempted suicide of a student, faculty member, or alumnus may precipitate the need for a school response.

Preparation for the Emergency:

The school district will have a phone tree in place to notify staff before arrival at school.

The school district will have provided inservice training to all staff on prevention, intervention, and postvention techniques. Once initial training has taken place, each fall new faculty and staff will be brought up to date with this information.

The school district will have selected the members of the Crisis Team (suggested: counselors, school psychologist, superintendent).

The school district will have provided Crisis Team members and any other staff members identified as being available as counselors during the crisis with up-to-date training.

The school district will have an agreement with the Valley Consortium of Counselors (or other outside agency, if desired) to provide mutual assistance during the crisis.

The school district will have identified a "safe" room for exclusive use during the crisis.

Death, Suicide or Attempted Suicide Reported:

Notified party informs Superintendent/Principal.

Telephone tree informs all staff members.

Extra counselors called in.

First Day

A. Morning faculty/staff meeting at 7:30 a.m.

   Staff reminded of their training and given information on the incident, and a written announcement to be read to the first class of the day.

B. Media contacts are handled by Crisis Team designee (most likely the administrative representative on the team).

C. Safe Room made available to students and staff, provided all day.

D. A counselor will go to each class and activity the student usually participated in to share feelings and answer questions. Counselors will also attend other classes as needed or requested.

E. Crisis Team member will contact family about funeral arrangements, memorial service, etc.

F. Counselors will take referrals from staff, parents, students and self-referrals.

G. After school faculty/staff meeting at 3:10 p.m.

   Review and staff support; Crisis Team gets referrals on high-risk students.

Second Day

A. Announcement from the Crisis Team administrator on funeral, memorial arrangements.

B. Students and staff encouraged to attend.

C. Safe Room still available for students.

D. Crisis Team provides assistance to family if needed.

E. After-school faculty/staff meeting.

   Continue monitoring high-risk students.

   Continue staff support.

F. Crisis Team will consider large group gathering to help other students process their feelings. Not all students will come forward or have someone to identify their needs.

G. A formal critical incident debriefing will be scheduled within three days if it is determined in (E) after school faculty/staff meeting that it is needed.

Appendix B

SUICIDE PREVENTION CURRICULUM

Goals and Objectives for Grades K-12

Unit	K	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
Self-Esteem	Recognizing the influence of others	Recognizing and explaining positive behavior	•Understand consequences •Importance of self to others	•Friendship development •Differences in self and others	Health and self-esteem	How personal qualities influence self-image
Feelings and Emotions	Recognizing feelings	•Identifying emotions •Group membership and emotions	•Recognizing pleasant and unpleasant emotions •Behavioral consequences	Differentiate between helpful and harmful behavior	•Use of communication •Emotions and decision-making	•Behavioral motivation •Emotional needs thoughout life
Coping	Coping with hurt and upset feelings	Recognizing abilities and limits	Sharing feelings of loss	•Personal loss •Pleasant and unpleasant stress	Support systems	Effective and ineffective coping behavior
Locating and Giving Help	Helping resources	Whom to ask for help	Friends as helpers	Helping a friend	•Peer groups •Asking for help	Effect of peers on behavior
Suicide and Depression						
Life Plan						

Grade 6	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12
Develop self-esteem by helping others	Enhancing self-esteem	Enhancing self-esteem	Enhancing self-esteem	Developing internal resources	Developing internal resources	Developing internal resources
•Managing feelings •Roles of significant others	Depression and suicide	Depression and suicide	Depression and suicide	Emotional health and behaviors that contribute to it	Emotional health and behaviors that contribute to it	Emotional health and behaviors that contribute to it
•Decision-making •Using the support system	Stress management	Stress management	Stress managment	•Social well-being •Communica-tion skills	•Social well-being •Communica-tion skills	•Social well-being •Communica-tion skills
•Effect of change •Adapting to change	•School, community resources •Self-help	•School, community resources •Self-help	•School, community resources •Self-help	Seeking and giving help	•Seeking and giving help •Community service	•Seeking and giving help •Community service
•Problem-solving process •Suicide •Getting help	•Problem-solving process •Suicide •Getting help	•Problem-solving process •Suicide •Getting help	•Suicide warning signs •Getting help	•Suicide •Referral •Being friend to oneself	•Suicide •Referral •Being friend to oneself	•Suicide •Referral •Being friend to oneself
					Personal mental health plan	Personal mental health plan

From *A Guide to Curriculum Planning in Suicide Prevention*, Wisconsin Department of Public Instruction.

Appendix C

Intervention

Potential Suicide Clues

Behavioral Clues
Sudden changes in behavior*
Drinking—taking drugs
Decline in school performance
Inability to concentrate
Withdrawing from others
Studying all the time to the exclusion of outside activities and friends
Fighting physically with family members
Running away
Giving away possessions
*This also includes those persons who seem to have become happy almost overnight. We assume their problems have been worked out when it's possible they have decided to end their lives and are now feeling the calm and peace of mind that follows the decision to die.

Verbal Clues
Direct:
"I feel like killing myself."
"Sometimes she makes me so mad, I feel like hanging (shooting, etc.) myself."
Indirect:
"Everyone would be better off without me."
"If this happens again. . ."
"I just can't take anymore. . ."
Any denial that problems exist when problems are obvious to others.

Situational Clues
Loss of relationship, friend, etc.
Loss of status (not making grades or team or exclusion from peer group)
Divorce of parents
Violence within the family
Parent over-emphasis on achievement
First year of college
Period of time immediately following long bout of depression or hard times
Physical problems along with changes in behavior or performance

Summary

The more risk criteria present, the higher the likelihood of a suicide attempt. These criteria are:

1. Specific plan
2. Availability of method
3. Location
4. Time
5. Ingestion of alcohol or drugs
6. Inaccessible for rescue
7. Lack of support—friends, family
8. Loss
9. Previous attempts
10. Chronic physical or emotional problems

Any one of these criteria in and of itself is reason for serious evaluation when a person expresses suicidal feelings. Certainly, when several of these factors are present, the risk is even greater.

What is most important regardless of how many factors are present is to intervene immediately. To minimize the situation because only one factor appears or, for that matter, because none are present, is a fatal mistake. Any reference to suicide demands intervention.

Specific Factors to Consider when Dealing with Depressed or Suicidal Adolescents

The suicidal feelings of an adolescent are the same as for an adult: Low self-esteem and feelings of worthlessness, deep depression accompanied by an overwhelming sense of hopelessness and helplessness.

However, the confusing and transitional nature of being an adolescent creates a further need for understanding adolescence itself in order to deal more effectively with an adolescent's suicidal feelings.

1. An adolescent is a person who is trying to grow up but sometimes gets very confused and/or scared and slips back into the security of being a child.

2. An adolescent usually tries very hard to be responsible and independent, but may not have a backlog of personal experience to carry through to the satisfaction of most adults.

3. Adolescents are people who almost always notice when there is a discrepancy between the rules and values espoused by adults and their behavior.

4. Adolescents are people who have the same intense emotional needs and feelings as adults but little understanding of how to recognize or cope with these emotions.

5. Adolescents are trying to figure out who they are now and who they want to be. They are particularly vulnerable to feeling a sense of worthlessness as a person.

6. Adolescents have a strong need to try out many things on their own, but they need a secure base to fall back on. With the increasing disorganization and breakdown in traditional family life, high rates of unemployment, enormous school pressures, competition for success, and peer pressure, many young people feel as if they are rocking in a boat that has no anchor.

7. Because of negative childhood experiences, some adolescents early on have written off adults as resources and place a high value on peer relationships. When the peer group does not take the adolescent seriously, or is not available to them, and when they haven't made a good connection with family members or other adults, they are really adrift.

8. Most adolescents have not formed a cohesive value system that would support them in what to live for, so even this important anchor of security may not yet be within their grasp.

9. Adolescents are locked into financial and emotional dependence on their families. When the family situation does not feel nurturing or supportive, the adolescent has very few options and may become trapped and helpless, unless he or she can express personal needs and have the needs taken seriously.

   In addition to being a "cry for help," an adolescent suicide attempt may be a "scream for change."

10. Often, adolescents have trouble identifying the underlying causes for their upset. They only know they feel terrible and they don't know what to do. Previously, they may have acted out their pain by getting into trouble at school, with the law, by running away, by trying drugs, alcohol, promiscuity; or they may have quietly faded into the wall, convinced that everybody picks on them and nobody is their friend.

    Alienation and isolation from significant others increase because their fear that in admitting their confusion and pain, they will not be considered grown up or they are afraid they will be rejected.

11. Sometimes what adolescents need to talk about involves violating family secrets which they may find terribly hard to do because revelation creates uncomfortable feelings of disloyalty, guilt or fears of retribution and rejection from the family. Not being able to discuss family problems increases the young person's isolation, an important factor in the development of suicidal feelings.

If one of your students threatened suicide or showed other signs of being suicidal, your action could make the difference between life and death.

In American society, suicide has historically been viewed as a shameful, dishonorable act. The person who has suicidal thoughts may feel ashamed and be reluctant to tell anyone how he/she feels. At the time the student needs somebody most, he/she is likely to be treated as an outcast if he/she asks for help. When he/she finally does reveal the way he/she feels, he/she is very sensitive to the reactions of the person in whom he/she has confided.

The best thing to do when someone makes suicidal statements is to show concern and to ask questions in a straight-forward and calm manner. Ask how serious the person is. Ask what feeling have prompted the desire to suicide. Ask about the home situation and relations with friends. Ask if the person has talked with anyone else about suicide. Ask if consideration has been given to the means of suicide and, if so, if any steps have been taken to procure those means, such as obtaining a gun or drugs. Ask if he or she would be interested in speaking to you or with someone who is more expert in such problems or with whom the student is more comfortable.

As a helper, you may begin with a statement such as, "You sure don't seem to have been yourself lately." "You appear to be kind of down." "Is something bothering you?" An affirmative answer to any of these might lead you to another question, such as, "Are you feeling kind of depressed?" "I guess sometimes it seems as though it's not worth it to go on struggling and fighting when so many disappointing things happen to you." An affirmative answer to that question might lead to, "Do you sometimes wake up in the morning and wish you didn't have to wake up, wish you were dead?" A "yes" might lead to, "Have you been thinking about killing yourself? Has suicide been on your mind?" "Do you have a plan about how you are going to do it?"

What started as a gentle, but direct, series of questions that any person might ask any other person can lead to a probing examination of the person's suicidal intent. Once the helping person has been taken into the confidence of the other, he may then begin talking about where professional help (if needed) can be obtained.

Your questions accomplish three important goals. They show that you are willing to discuss the subject and that you are not appalled or disgusted by it. They will open lines of communication, allowing the students to talk about the way he or she feels, which alone may help the person to feel better and to believe that someone will help. Also, the questions will help you, and, subsequently, often someone else, to evaluate the seriousness of the problem.

In evaluating danger, be aware that as a general rule, the more specific the plan, the greater and more imminent the danger. If detailed plans have been made and the means of suicide obtained, the danger is not only great—it is immediate. This does not mean that someone with only vague suicidal notions should not be taken seriously; he or she may be in the early stages of planning, or indeed, the act may be carried out without the carefully detailed plans that characterize many suicides. It is important to recognize that this is a temporary state of mind and that the crisis will pass. But because adolescents are impulsive, they must be taken seriously when a suicidal intention is expressed.

In a recent study of adolescent suicides, it was learned that nearly half of the suicidal youngsters were involved in some form of drug or alcohol abuse shortly before their suicidal death. This does not necessarily imply that it was substance abuse that led to the death. Rather, the same factors that made them unhappy enough to commit suicide probably contributed to their abuse of drugs. Many factors were encountered that seemed, in one way or another, to contribute to their overall suicidality. For example, nearly two-thirds were reported to have been on poor terms with their families, and nearly 90 percent felt that their families did not understand them. Not being appreciated or understood by their families seems to be the most common factor in the continuing chaos and unhappiness in the youth's life.

A surprisingly large number of those studied (42 percent) were reported to have been in physical fights with other persons and an equally large number reported to have engaged in serious conflict with persons in their own families. It was also reported that there was a considerable amount of physical and assaultive behavior among their family members in general.

It should be pointed out that suicidal youth, regardless of the specific trigger factor, all have one thing in common: a nagging lack of optimism, lack of hope about their future and an enormous sense of unhappiness and general hopelessness coupled with a lack of understanding of time and that situations can change with time.

Even if you are successful in talking openly and frankly with the potentially suicidal student, it is important not to take too much upon yourself. People who are seriously suicidal will sometimes reach a point where they purposely mislead those who are trying to help them by acting as if the crisis has past. Whenever a serious risk of suicide exists, suggest that a person get the help of a trained professional through a suicide prevention center or a mental health clinic, private therapist, a clergyman, or through some other appropriate services in your area.

If the student refuses or is incapable of seeking help, consult with other school staff (counselor, administrator, psychologist) for advice on how to handle the situation. Although each situation must be judged individually, in most instances parents should be informed of your concerns. However, school personnel do act "in locoparentis." As a school employee, you are clear of any liability for breach of confidence when you take action on behalf of a student whose behavior is likely to be dangerous to himself or others. If the student requests your confidence, explore the reasons for his or her need for secrecy. It may stem from his/her fear of the reactions others might have to his/her frightening and forbidden thoughts about suicide. The manner in which you respond to his/her fears and the anxieties can do much to allay these feelings. In any event, concern for confidentiality must be secondary to concern for the student's life. Most important, don't delay your actions.

Finally, your efforts in helping the suicidal person and in making sure that professional help is obtained may very likely save a life. The common belief that suicide prevention is only temporary and that the person will eventually take his or her life anyway is just a myth. People have a will to live which can become dominant again. With proper guidance or treatment, the hopelessness can disappear the potential suicide victim can be restored to full, active and happy living. Assistance is available. You may be an important part of that help and a vital first link is assuring that professional assistance is obtained and that a life is saved.

Appendix D

POSTVENTION

The Grief Experience*—Manifestations

Stage and Time Period	Cognitive	Affective	Somatic	Social Relationships	Coping Mechanisms
Shock **Hours to Days**	Slowed and/or disorganized thinking Blocking Suicidal thoughts Wish to join deceased May appear unaffected	Psychic numbness Blunting Outbursts Euphoria Hysteria Unaffected	Physical numbness Feeling of unreality Feeling of being outside body Hypo or hyperactivity Talkative	Passive Unaware of others	Denial Intellectualization Depersonalization
Protest **First Week to 3 Months**	Preoccupied with thoughts of deceased Searching Rumination Dreams Hallucinations	Sadness Fear Anger Guilt Relief Irritability Yearning Sense of presence	Physical distress Pain in chest Sleep disturbance Fatigue Nausea Decreased appetite Weight loss	Dependent Seeks help	Regression Projection Introjection
Disorganization **3 to 6 Months**	Confusion Aimlessness Slowed thinking Loss of interest Decreased self-esteem Focus on memories	Sadness Loneliness Depression Meaninglessness Apathy Feeling of unreality Intense anguish	Deceased inside self Adopt traits and mannerisms of deceased Restlessness Decreased resistance to illness	Withdrawn Avoids others Lacks initiative Lacks interest	Regression Projection Introjection
Reorganization **6 Months to 2 Years**	Develop realistic memory of deceased Develop pleasure in remembering Return to previous level of functioning Find new meaning in life	Experience both sadness and happiness	Return to previous level	New or renewed social relationships New or renewed interests	Resumes former coping and/or adds new coping mechanism

*Categories are not as distinct as this figure indicates. Stages, time periods and manifestations vary greatly among individuals.

AFTERMATH OF CHILD AND ADOLESCENT SUICIDE

Reactions to Suicide

The reactions of individuals close to one who has committed suicide are likely to be complex (Worden, 1983), but typically include the following:

(1) SHOCK, including emotional, physical and cognitive immobility.

(2) DENIAL, including non-belief of the death announcement and refusal to accept the fact of death, or that it was due to suicide.

(3) LONELINESS, which may create a sense of emptiness and isolation.

(4) ANGER, which may indicate a need to blame, directed toward the deceased, as well as toward medical agencies, friends of the deceased, etc.

(5) PAIN, because anxiety can create emotional pain and the strain of grief can cause physical distress.

(6) PANIC, causing fear of loss of control, fear of own stability, fear of not knowing what to do.

(7) SHAME, because of the stigma associated with suicide.

(8) GUILT, about what the survivor might or should have done to prevent the suicide, as well as about how he or she may have contributed to it.

(9) DEPRESSION, resulting from a gradual erosion of coping mechanisms.

Additional special factors may add to the stress faced by parents when the suicide is that of a child or adolescent. The loss of a child is among the most burdensome of all to parents, and it may be compounded with stigma and guilt in the case of suicide. Unfortunately, there is little information on this matter, which may reflect both the unwillingness of many families to be investigated after a suicide, and the reluctance of research workers to tackle such a difficult and painful task. However, existing information emphasized the use of the following strategies during post-suicide counseling (Worden, 1983):

(1) Being familiar with the stages of the grieving process (see Table I).

(2) Helping establish accurate communication between family members.

(3) Reality testing feelings of guilt. For example, people may be helped to see that they had done all they could for the deceased. Sometimes there is good reason for guilt and the bereaved person will need assistance in accepting the feelings of guilt and preventing them from becoming distorted.

GUIDELINES FOR ACTION FOLLOWING TRAGIC DEATH OF A CO-WORKER

Postvention is the name of the overall process which involves developing a protocol and set of activities in anticipation of a death in or related to the workplace. A protocol is the plan, determined in advance, for postvention efforts and for the personnel and resources to accomplish them.

Postvention Activities:

1. Develop a procedure for notifying employees and others who need to know about a workplace-related death or unusual life-threatening incident.

2. Consider designating person(s) to deal with the media.

3. Designate staff, EAP contractors, or other mental health professionals who will be available as counselors to employees the day and day after the incident.

4. Plan a Critical Incident Debriefing for directly affected staff.

5. Consult family or close associates concerning a memorial or service.

6. In order to develop a Protocol, several planning and training procedures should be followed.

    a. Planning: Protocols, guides and designation of key personnel must be designed in advance by the organization.

    b. Training: All staff who will perform postvention services must have related training in such areas as incident debriefing, grief counseling or disaster management.

    c. Prevention and Intervention: A workplace death or life-threatening event is an occasion for a critique or investigation to develop preventive measures in such areas as job safety, drug and alcohol counseling, and others.

Prepared by Bob Deaton

Missoula County Critical Incident Team, 1990.

"TAKING CARE OF THOSE WHO TAKE CARE"

A DEBRIEFING GUIDE FOR SCHOOL MEMBERS

Following any tragic death of a school member, teachers, staff and administrators need to share thoughts and feelings and reach a sense of closure about the event. The critical incident debriefing is a planned, thoughtful way to provide for the needs of staff and acknowledge the loss of the person who died.

Formal debriefing utilizing a trained debriefing team, should be considered, especially if everyone on the school staff was effected by the incident, or if no one is available to facilitate from the school.

When should it be held: 24-72 hours after the news of the death is optimum.

Who should attend: All school staff who feel directly affected by the death of a fellow teacher, staff member or student.

What is a debriefing like:

1. Setting and time—A private conference room where people can be seated around a large table for about two hours is best.

2. Ground rules—Free expression is encouraged and everything said is confidential. The focus is upon the personal expression of those attending. It is not an administrative critique or investigation in any sense.

3. Expression and exchange—Each person is given the opportunity to talk about his/her relationship to the deceased and how they feel affected by the incident. Next cognitive work is done by members as they make sense and make peace with themselves through exchanging thoughts about the life and death of this person.

4. Stress management instruction (optional)—Some debriefing sessions end with suggesting specific techniques for self-care in dealing with stresses related with a tragic incident. These include sleep disturbance, nutrition and exercise and dealing with intrusive mental images.

GUIDELINES FOR ACTION FOLLOWING THE DEATH OF A CHILD AND ADOLESCENT

Postvention Efforts for Counselors and Therapists:

1. Consider location. Some parents and families may need to be seen in their own homes rather than the therapist's office.

2. Anticipate anger. If there has been therapy prior to the death, there may be anger toward the therapist or the therapy process.

3. Encourage any expression of feelings. While it is the most obvious measure, family members often receive signals from others that they do not want to hear about the child's death because of their own uncomfortableness. The counselor needs to invite the family or parents to say what they need to say.

4. Immediate cognitive issues. Be alert for family members' request to make sense of the tragedy, and be clear about the need to work through thoughts and ideas in addition to feelings. Typical cognitive issues are: "What else could I/we have done to save him? It's all my fault she died. What will people say about the suicide? He doesn't seem to be really gone. I can't stand to think of all we invested in her, and now she's gone forever."

5. Spiritual issues. Suicides and other tragic deaths involve the core value about the meaning and value of life to the person. Saving people from suicide involves appealing to their personal beliefs about life being worthwhile. The aftermath is often difficult for people who have not separated their religiousness from spiritualness. A competent clergyman should deal with spirituality where appropriate.

6. Practical issues. Assist the family in planning what they would like to do with the deceased's belongings, his room, car, etc. Discuss memorial services and contributions. Help the family sort out the difference between what they truly want and what they perceive others want from them. Remind parents that serious martial conflict often erupts after a tragic child death in the family. Appeal to them to work together. Offer to help them later as needed.

7. Closure. Assist the family with moving along in the grief and letting go processes. Since closure varies greatly among different people, note signs of getting "stuck" and not moving along.

Prepared by Bob Deaton, Professor, Department of Social Work, University of Montana

Material Taken From: Grief Separation and Loss
Provided by
CARE PROGRAM
Chemical Awareness Through Responsive Education
Great Falls Public Schools

SUPPORTING CHILDREN THROUGH GRIEF

CAROL HELOGOFF, RN

Handouts courtesy of
MDMC

THE THREE TASKS OF GRIEF FOR CHILDREN

First Task

To understand that the person is dead.

What helps?

1. Tell children honest, direct and factual information in order to help them understand that the person is dead.
2. Use the word "dead."
3. Allow time for repeated questions, speculations, and the telling of the story. Children may need to hear information many times.
4. Give children choices about participation in the illness, death, viewing, funeral, discussions about the death.
5. Be honest with information and your own feelings about the death.

Second Task

To feel the feelings of grief.

What helps?

1. Listening, accepting and caring help children express their grieving feelings.
2. Encourage lots of physical expression with sports, active play and safe expression of anger.

3. Reflect back to the child what you observe in their play and language rather than ask questions, give interpretation or advice. Allow, don't fix.

4. Lower expectations. Grief takes tremendous physical and emotional energy. It will take time to return to normal standards of performance.

5. Refer to therapy if the child's grief behavior is creating more negative events which will further drain his/her coping abilities. Management first, support later.

Third Task

To go on living and loving.

What helps?

1. Believe in the return to wellness of a child and family even when they cannot.

2. Celebrate the steps they take toward healing.

3. Be aware of our own grief and our own needs for support.

4. Allow for "time out" from grief when children can fully enjoy.

THREE TASKS OF GRIEVING FOR CHILDREN

First Task: To understand that the person is dead.

Second Task: To feel the feelings of grief.

Third Task: To go on living and loving.

FIRST TASK: To understand that the person is dead.

This is a thinking or cognitive process.

1. Children want to know what happened. They need honest, direct, factual information in order to understand that the person is dead. Curiosity and speculation about the facts of the death are healthy parts of the process.

2. The word "dead" is an abstract concept that takes time to understand, especially for children. They will use the word "dead" long before they grasp the meaning.

3. Impermanence of death. Children often feel that the person who died is gone temporarily. There is a lag time between hearing the word "dead" and feeling the feelings about the person being gone. The younger the thinking ability, the longer the lag time.

4. The grieving process is cyclical. Children regrieve on a daily, monthly and yearly basis, as well as throughout their lives.

5. Children overgeneralize a concept first (if Dad died in the hospital, all people who go to the hospital will die), then accommodate (some people die in hospitals; some people get well). (Piaget)

6. Death data bank. Children's concepts about death too often come from their death data bank of television, rock music, dead animals along the road, etc. The human experience of death is not easily spoken by adults to children. We must add our contributions as adults to their death data bank with open conversation about death as a part of life.

What helps?

1. Circle time, family talking time. Have a telling ritual where family members can tell what has happened, the stories about the death, the memories...

2. Help a child create a memory box of pictures and treasured items which can be added to over time.

3. Children should be included. Let them make choices about how much to be involved in the illness, death and funeral of a loved one.

4. Repetition helps. Answer questions over and over for children. Keep the focus on what the child wants to hear.

5. Tell the truth. Involve them honestly in the process at the hospital, the viewing, the funeral, the cemetery, if they choose. Use correct language such as the word "dead."

6. Children learn from adults. It is appropriate and helpful for children to witness and be included in an adult's grieving, but not to become a major caregiver for an adult.

SECOND TASK: To feel the feelings of grief.

This is a feeling or an affective process.

1. Goneness. Grief becomes a feeling in out bodies of the "goneness" of the person who died.

2. Grief is a wound to our psyche. We, as humans, have an innate ability to heal our psychic wounds as we do our physical wounds.

3. Grief is physical. Sweating, crying, sleeplessness, sleeping, eating, not eating; grief needs physical outlets: crying, safe yelling, safe hitting, walking, running, cleaning, singing, etc.

4. Movement and play is the language of grief for children. This language is full of symbols and metaphors about their feelings.

5. Defenses. Sharing feelings can be difficult and scary. It's normal to hide our feelings after a death. We use defenses to hide our feelings.

Defenses	Behavior	Meaning
Acting Out	Showing a Display of Power	Hiding Powerlessness
Overachieving	"Trying" to be Good	Feeling "Bad" or Responsible for the Death
		Controlling an Uncontrollable World
Withdrawal	Quiet, Unmotivated	Expressing Powerlessness

6. Children often feel responsible for the death in some way. They may feel guilty for not trying harder to stop a bad thing from happening. This is a child's natural egocentricity.

What helps?

1. Listening, accepting and caring help children express their grieving feelings.

2. Encourage safe, physical expression like sports, active play and safe release of anger.

3. Reflect back to the child what they are doing in language and play rather than asking questions, giving interpretations or advice.

4. Lower expectations. Grief takes tremendous physical and emotional energy. It will take time to return to normal standards of performance.

5. About a child's guilt. Reassure them of the facts that show they could not have prevented the death. Then if they still insist, listen patiently and love them.

6. Refer to therapy if the child's grief behavior is creating more negative events which will further drain his/her coping abilities. Management first, support later.

THIRD TASK: To engage fully in life.

1. Different ways of coming to terms with the death.

   a. For some people "it never happened." The person who died is still "alive" for the one who grieves.

   b. Some people try to "get over it" (the death) by using philosophical, religious or rational techniques.

   c. Some people try to "fill the hole" that is left by the death of someone close with other activities, relationships.

   d. Some people learn over time to "live with it." The person who died is still a part of their lives in memories. The death is a part of who they are as they go on living.

2. When we begin to heal, we move from the "why did it happen" question to the "what can I do now" question, to the "how am I going to do it" question.

3. Sometimes someone who is grieving truly enjoys himself in life and then feels guilty and disloyal to the dead one. Encourage children and adults to take "time out" from grief. This revives energy for the other times when they are consumed with hard feelings.

What helps?

1. Believe in the return to wellness for a child and family even when they cannot.

2. Celebrate the steps they take toward healing.

3. Be aware of our own grief and our own needs for support.

4. Allow for "time out" from grief.

Appendix E

NEA—Human & Civil Rights

Action Sheet—Teen Suicide

The death of a young person is always a tragedy. It is an even greater tragedy when a child has taken his or her life. Such an event affects many besides the victim; other students, the family, teachers and other school employees, and the community itself. Sometimes "copycat" suicides occur among young people, which spread the tragedy even further.

Suicide is the eighth leading cause of death in the United States, but it is the second leading cause of death among young people ages 15-19 (after traffic accidents), and it is also the most preventable. Rates in this group have quadrupled in the last 30 years and are continuing to increase. The federal government records roughly 7,000 suicides a year for persons aged 15-24, but experts believe many more are not identified as suicides. As many as nine of ten teen suicides can be prevented; experts note that for every actual suicide, there are more than 100 attempts. The behavioral patterns and stresses that researchers find in the backgrounds of suicide victims surface early in children's lives and school careers.

Since NEA members are so close to young people, they are often the first to notice when students are troubled, as well as the first to be consulted by students with personal problems. Since suicide is such an alarming problem, affecting students, families, and whole communities, all educators need to know suicide's warning signs to respond appropriately.

NEA Resolution C-24
Student Stress

The National Education Association believes that there are increasing mental, emotional, and environmental pressures upon children and youth which result in drug and alcohol abuse, violence, vandalism, school dropouts, and suicide.

The Association supports stress management programs that address the needs of children within both school and community settings and that provide follow-up support. The Association further supports workshops to prepare school personnel and parents/guardians to help students deal with stress.

The Association urges local and state affiliates to seek legislative support and publicity for these programs.

NEA Resolution C-28
Suicide Prevention Programs

The National Education Association believes that suicide prevention programs, including prevention, intervention, and postvention must be developed and implemented. The Association urges its affiliates to ensure that these programs are an integral part of the school program.

Pertinent Information

- Three of the 1990 Health Objectives for the Nation dealt with suicide. These are: (1) a reduction in the rate of suicide among people ages 15-24 to below 11 percent per 100,000; (2) a 50 percent increase in the proportion of this population who can identify a community agency that can help in a stressful situation; and (3) an increase of 60 percent in the proportion of this population who can identify an accessible suicide prevention hotline.

- The National Adolescent Student Health Survey in 1988 reported that one of every seven adolescents attempts suicide; approximately 5,200 young people between the ages of 15 and 24 kill themselves each year. Many suicides are undetectable (auto accidents, other self-destructive behavior), and estimates generally run to between 5,000 and 10,000 teen suicides each year.

- Many more young men than women kill themselves, with the gender ratio over four to one. Suicide by firearms is the most common method, accounting for nearly 60 percent of all suicides (79 percent of all firearm suicides are committed by white males). More women than men, however, attempt suicide, with a gender ratio about two to one. For each completion, there are about ten attempted suicides.

- The American Medical Association reports (1992) that thousands of American Indians/Alaska Native teenagers face risk factors greater than those of other ethnic groups, including a death rate more than twice as high as any other group. The rate of death by suicide among Native American youth is 26.3 per 100,000, compared to 12.4 per 100,000 for the teenage population as a whole.

- According to the *Report of the Secretary's Task Force on Youth Suicide* published by the Department of Health and Human Services in 1989, suicide is the leading cause of death among gay male, lesbian, bisexual, and transsexual youth. They belong to two groups at high risk of suicide: sexual minorities and the young.

Prediction and Response

- Research finds that suicide, while complex, can often be predicted from dysfunctional patterns of relating to threat, pain, stress, and failure. Children who attempt suicide often find themselves isolated, rejected by peer groups, and unhappy in school. Early childhood school personnel can be the first to identify these symptoms.

- Family conditions associated with suicide include family history of suicide; family history of mental disorder or substance abuse; family violence, including emotional, physical, or sexual abuse; and separation or divorce.

- School-based suicide prevention programs can help reduce the teenage suicide rate. Since suicides often increase after media reports of other suicides, some school programs focus not on suicide but on the issues of adolescence. These programs attempt to enhance students' coping mechanisms and increase their awareness of the options they have in life.

- School systems find it easier to fund prevention programs if they separate school and community responsibilities. The most economical way for schools to finance their portion is to use existing personnel and to plan the program before a crisis occurs.

- While schools alone cannot meet needs related to students' family circumstances or other conditions outside the immediate scope of the school and its curriculum, they can help to eliminate or reduce school-induced stress through building students' self-esteem.

Warning Signs

A number of warning signs can tell if a young person needs help, including unusual changes in eating and/or sleeping habits; unexplained or unusually severe violent or rebellious behavior; withdrawal from family or friends; running away; persistent boredom and/or difficulty concentrating; drug and/or alcohol abuse; unexplained decline in quality of schoolwork; unusual neglect of appearance; radical personality change; psychosomatic complaints; preoccupation with themes of death; giving away prized possessions; expressing suicidal thoughts, even jokingly; previous suicide attempts; complaints and verbal hints; becoming suddenly cheerful after a period of depression; and putting his or her affairs in order—for example, cleaning his or her room and throwing things away.

Suggested Procedures for Prevention and Response

While individual NEA members may not have specific responsibilities in suicide prevention and response, they do have a strong interest in making sure that guidelines, personnel resources, and responsibilities have been clearly defined, and that there are plans for what to do when an emergency develops. Some school-based strategies for suicide prevention and response include the following:

- Decide in advance who is to be in charge when a crisis occurs; network with suicide prevention groups.
- Hold thorough inservice programs for all staff each year, especially in high schools and intermediate schools.
- Identify telephone trees to facilitate rapid communication to persons who need information and/or need to be involved; notify key people within the school system immediately.
- Do not wait to begin activity; prepare a general announcement to be given by the principal or designee; be as truthful as possible when students ask questions; plan to hold a faculty meeting as soon as possible, at least at the end of the school day.
- Invite identified friends of the deceased to meet as a group, preferably with one or two adult leaders present.
- Ask school staff to make themselves available to parents and other members of the community, if appropriate.
- Plan appropriate follow-up activities as needed for students and families, including group meetings for bereaved students, individual sessions with mental health professionals, and crisis debriefing for persons involved in crisis management.

Recommendations for State and Local Education Associations

Local and state education associations and their members can lead in ensuring that adequate guidelines, training, and programs are in place for prevention, intervention, and follow-up in dealing with the continuing problem of teen suicide. Faculty, parents, students, and others must have confidence that school responses will be prompt and appropriate. Associations can conduct their own training and workshop programs, distribute reports and recommendations, publicize program and informational needs, and negotiate explicit guidelines on member responsibilities in teen suicide prevention and response. Respect, protection, guidance, and a listening ear are essential for students. NEA members can lead in making the difference.

Organizations Dealing with Teen Suicide and Related Issues

American Academy of Child Psychiatry, 3615 Wisconsin Avenue, N.W., Washington, D.C. 20016.

American Society of Suicidology, 2459 Ash Street, Denver, Colorado 80222.

Health Information Network, 1201 16th Street, N.W., Washington, D.C. 20036. A cooperative project of the NEA, the National Association of School Nurses, the U.S. Public Health Service, the U.S. Centers for Disease Control, and the American Academy of Pediatrics.

National Institute of Mental Health, 5600 Fishers Lane, Rockville, Maryland 20857.

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Young People in Crisis (Videocassette). Available with guide and take-home booklet, from Exar Communications, Inc., Distribution Operations, 267B McClean Avenue, Staten Island, New York 10305.

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